BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the proposed amendment of ARM 24.29.1402, 24.29.1404, 24.29.1406, 24.29.1416, 24.29.1427, 24.29.1430, 24.29.1431, and 24.29.1522, the proposed amendment and transfer of 24.29.1504, and the proposed adoption of NEW RULE I, all related to the workers' compensation medical fee schedule for facilities	)))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT, AMENDMENT AND TRANSFER, AND ADOPTION

TO: All Concerned Persons

1. On September 19, 2008, at 10:00 a.m., the Department of Labor and Industry (department) will hold a public hearing to be held in Montana Department of Transportation Auditorium, 2701 Prospect Avenue, Helena, Montana, to consider the proposed amendment, amendment and transfer, and adoption of the above-stated rules.

2. The department will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., on September 12, 2008, to advise us of the nature of the accommodation that you need. Please contact the Workers' Compensation Regulations Bureau, Employment Relations Division, Department of Labor and Industry, Attn: Jeanne Johns, P.O. Box 8011, Helena, MT 59624-8011; telephone (406) 444-7710; fax (406) 444-3465; TDD (406) 444-5549; or e-mail jjohns@mt.gov.

3. GENERAL STATEMENT OF REASONABLE NECESSITY: The 2007 Legislature passed Chap. 330, L. 2007 (HB 738) and Chap. 117, L. 2007 (SB 108). These sections of law require the Department of Labor and Industry to establish administrative rules setting the reimbursement rates for facilities that provide medical services to injured workers. Through this notice, the department is proposing to adopt a Medicare-based fee schedule for workers' compensation reimbursement. The department proposes this approach because Medicare is a nationally recognized system that is already widely used and understood by many health care providers. Further, in comparison to the previously established fee schedule system, the Medicare fee schedule is more uniform because the methodology results in a predictable reimbursement no matter where in the state the injured worker is treated. A Medicare system also provides cost containment because it is based on costs rather than charges. Using this fee schedule would also allow comparison of workers' compensation rates to Medicare and to other commercial payer rates which also use the Medicare methodology.

The department developed proposed NEW RULE I (the Medicare-based fee schedule) following substantial consultations with a leading medical fee schedule developer, INGENIX Corp, representatives from Plan No. 1, No. 2, and No. 3 (including third-party administrators), and representatives of acute care hospitals and ambulatory surgical centers. Proposed NEW RULE I represents what the department believes is an appropriate methodology for a facility fee schedule for the providers and the payors (insurers). The department initially proposed NEW RULE I in MAR Notice No. 24-29-228 on April 24, 2008. After receiving numerous comments from interested persons who requested additional time and who suggested numerous changes, the department decided to delay implementation, change the proposed rule, and renotice the proposed rule. The comment period for interested persons is now based on the proposal as set out below, with the deadline for comments as indicated in this notice.

In addition to proposing a Medicare-based fee schedule, the rules propose to change the terminology where needed in order to clarify that the proposed rules cover all providers that care for an injured worker including ambulatory surgery centers, known as ASCs. Previously, ASCs were not regulated by the fee schedules developed pursuant to the Workers' Compensation Act. As a result, ASCs were being reimbursed at 100 percent of billed charges, which is not comparable with hospital outpatient service reimbursements. The department's general requirement to set fees pursuant to Chapter 330 includes ASCs. In order to clarify that ASCs will be included in the fee schedule, the department proposes to use the term "facility" throughout because the term includes both hospitals and ASCs.

The department has developed the proposed fee schedule to reimburse all facilities based on costs rather than charges for services in order to establish equitable payments across the system rather than budget neutrality on an individual hospital or ambulatory surgery center basis. The department acknowledges individual facilities will experience increases and some will experience decreases. The department believes more efficient hospitals will still be more profitable. The current discount factoring system for hospital facilities did not address equity of reimbursement for services across the state. The department believes the proposed fee schedule is set at 65 percent above Medicare because it used Montana specific workers' compensation data in developing the cost-based system.

The proposed changes clarify that the proposed facility fee schedule uses a Medicare type reimbursement system. However, the proposed schedule is not Medicare's fee schedule and does not include its Prospective Payment System or Medicare's allowable procedures and medications. The department acknowledges Medicare does not allow for some specific treatments. Under workers' compensation law, however, only those medical treatments which have been excluded by rule under ARM 24.29.1526 are not payable. There are currently only three such treatments. Decisions concerning all other treatments should be made by the injured worker's treating physician, taking into consideration reasonableness and the prior authorization rules.

The department believes that there is reasonable necessity to amend, rather than repeal, the existing fee schedule rules despite the fact that some of the rules will be superseded by new rules for services provided on or after November 1, 2008. The department believes that disputes over medical services and fees payable sometimes linger for years, and that payment of old bills can be handled more promptly when the applicable rules are still "on the books."

The department also believes that in some cases, adoption of new rules will be less confusing than merely amending the existing rules and in other cases, amending the existing rules will suffice. Where rules are simply amended, the old version of the rule applies until the amendment takes effect and the new version applies on or after the effective date. The department notes that when new rules are adopted, each will be assigned a unique rule number, which will assist providers, insurers, and the department in making sure that the correct rule is being applied with respect to services furnished on or after the applicability date of the rule. The department believes that the adoption of the proposed new rule makes it more likely that the correct payment is made by the insurer to the provider.

The department is proposing that the amendments and NEW RULE I will apply to discharge dates on or after November 1, 2008.

This general statement applies to all the proposed rules changes, with specific or additional rationales included for each rule.

4. The rules proposed to be amended provide as follows, stricken material interlined, new material underlined:

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) Payment of medical claims ~~shall~~ must be made in accordance with the schedule of ~~nonhospital~~ facility and nonfacility medical fees ~~and the hospital rates~~ adopted by the department.

(2) through (7) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-510, 39-71-704, MCA

REASON: There is reasonable necessity to change the terminology in the rule from "nonhospital medical fees and hospital rates" to "facility and nonfacility medical fees" due to the changes enacted by Chapter 330. The proposed change in terminology clarifies that ASCs will be covered by the new rules. For any services provided before the effective date of the amended rule, ASCs will continue to be reimbursed at 100 percent of charges. Following the effective date of the amendments, ASCs will be reimbursed according to the proposed fee schedule. The department is proposing that the amendments will take effect on November 1, 2008.

24.29.1404 DISPUTED MEDICAL CLAIMS (1) and (2) remain the same.

(3) ~~Hospital~~ Facility records ~~shall~~ must be furnished to the insurer upon request. ~~Hospitals shall~~ Facilities must obtain~~, upon admission,~~ the necessary release by their administrative procedures.

(4) remains the same.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

REASON: There is reasonable necessity to change the terminology in the rule due to the changes enacted by Chapter 330. The proposed amendments change the reference from "hospital" records to "facility" records, thereby clarifying the terminology to include not only hospital services, but services provided by an ASC. Because the change is minor and straightforward, the department does not believe it is necessary to propose a new rule with a beginning date to address the issue of including ASCs in the rule's requirements.

24.29.1406 ~~HOSPITAL~~ FACILITY BILLS (1) ~~Hospital~~ Facility bills should be submitted when the injured worker is discharged from the ~~hospital~~ facility or every 30 days.

(2) To the extent possible, electronic billing must be utilized by both providers and payers in the billing and reimbursement process to facilitate the rapid transmission of data, lessen the opportunity for errors, and lessen system costs.

(3) It is the responsibility of the facility to use the proper service codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(4) Insurers must make timely payments of facility bills. In cases where there is no dispute over liability, the insurer must, within 30 days of receipt of a facility's charges, pay the charges according to the rates established by these rules.

(5) Insurer-initiated medical necessity review, claim audits, and other administrative review procedures may only be conducted on a post-payment basis.

AUTH: 39-71-203, MCA
IMP: 39-71-105, 39-71-107, 39-71-203, 39-71-704, MCA

REASON: There is reasonable necessity to amend this rule to implement changes enacted by Chapter 330. The proposed changes clarify the terminology to include not only hospital services, but services provided by an ASC. In addition, because ARM 24.29.1427 is proposed to have a specific ending date for its applicability, language in (4) which is based on ARM 24.29.1427 is proposed to be added here because it will continue to apply to all services provided. This language naturally falls within the subject of the payment process used for submission and payment of facility bills.

In addition, the rule requires the electronic submission of bills to the extent possible to lessen the errors in the system that have been reported to the department. When medical bills are submitted electronically for inpatient or outpatient hospital or ASC

services, facilities will no longer need to document the billing by attaching documentation in the majority of cases. However, records will continue to be required for providers who bill separately from the facility or when prior authorization of treatment is required. Insurers may require documentation for outpatient procedures performed in the facility when the documentation is not available from another provider. Examples of such documentation are reports from lab work, x-rays, and physical therapy treatments billed by the facility.

Further, the department is considering legislation to allow adoption of Medicare's current code structures and MS-DRGs on an ongoing basis. Currently, due to the prohibition contained in 2-4-307(3), MCA, the department cannot adopt the Medicare system schedules without notice and opportunity for comment through the ARM process. Therefore, the department cannot at this time adopt the Medicare coding changes to occur concurrently with Medicare.

The department notes that numerous vendors have software and groupers available that can be used by everyone. The cost of purchasing software is to be worked out between the providers and payers. It is not necessary for everyone to use the same software, but it will be necessary for the payer's software to "talk to" the provider's software. There are many different groupers that providers and payers may access at no charge. One such grouper is available at www.hospitalbenchmarks.com.

Regarding (4), the department is considering proposing statutory language to include a penalty in the prompt payment provision and to clarify that payments must be made within 30 calendar days of receipt. The department notes that initial liability for acceptance of a claim is the statutory responsibility of the insurer and disputes are addressed through the department's mediation process. The department is unaware of circumstances under the proposed billing system where information would be so incomplete that the payer could not identify an appropriate MS-DRG code in order to process the bill for services.

Regarding (5), the rates proposed by the department assume that prompt payment is made by the insurer to the health care provider because of the time value of money. Numerous providers have indicated to the department that payment is often delayed by insurers. The proposed rules clarify that insurers may continue to dispute medical necessity and conduct other claim audits, but those activities must be conducted on a post-payment basis. If sufficient data are received indicating additional rules are needed to address over and under payments, the department will propose additional rules at a later date.

Finally, there is reasonable necessity to amend the implementation citation to reference two additional statutes, in order to more fully identify those provisions of law which the rule implements. The department believes that the proposed amendments to the rule further implement the public policy of the workers' compensation system as being intended to speedily provide benefits and be self-administering, as well as further defining the obligation of an insurer to promptly handle claims.

24.29.1416 APPLICABILITY OF DATE OF INJURY, DATE OF SERVICE

(1) The amounts of the following types of payments are determined according to the specific department rates in effect on the date the medical service or services are ~~is~~ provided, regardless of the date of injury:

(a) remains the same.

(b) ~~hospital~~ facility charges;

(c) remains the same.

(d) ~~medical equipment and supplies~~ DME.

(2) When services, procedures, or supplies are bundled for purposes of billing and the bundling covers more than one day, the date of discharge must be used as the date the services are provided for purposes of this rule.

AUTH: 39-71-203, MCA
IMP: 39-71-704, 39-71-727, MCA

REASON: There is reasonable necessity to change the terminology in the rule due to the changes enacted by Chapter 330. The rule directs that payments for medical services be determined by the specific department rates in effect on the date the medical service is provided, or the date of discharge when services are bundled that cover more than one day. The proposed amendments change the terminology from hospital to facility in order to include ASCs. The changes also recognize the new bundling payment methodology used with MS-DRG and APC coding. Because the change is minor and straightforward, the department does not believe it is necessary to propose a new rule with a proposed beginning date.

24.29.1427 HOSPITAL SERVICE RULES FOR ~~CLAIMS ARISING ON OR AFTER~~ SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH OCTOBER 31, 2008 (1) This rule applies to services provided from ~~on or after~~ January 1, 2008, through October 31, 2008.

(2) and (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1427 to implement changes enacted by Chapter 330. This proposed change corrects an error in the previous adoption to specify that the rule applies to services provided during the specified timeframe rather than claims arising on or after the specified timeframe. Because NEW RULE I is proposed to direct payment of facility bills on or after November 1, 2008, the proposed changes also set an ending date.

24.29.1430 HOSPITAL RATES FROM JULY 1, 1998, THROUGH JUNE 30, 2001 (1) through (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase to clarify the dates of applicability of the rule. This proposed change corrects an error in the previous adoption to specify that the rule applies to services provided during the specified timeframe.

24.29.1431 HOSPITAL RATES FROM ~~BEGINNING~~ JULY 1, 2001, THROUGH OCTOBER 31, 2008 (1) through (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1431 to implement changes enacted by Chapter 330. NEW RULE I is proposed to direct payment of facility bills on or after November 1, 2008, so the proposed change sets an ending date.

24.29.1522 MEDICAL EQUIPMENT AND SUPPLIES PROVIDED BY A NONFACILITY FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2008

(1) This rule applies to ~~equipment and supplies~~ DME provided by a nonfacility on or after January 1, 2008.

(2) Except for prescription medicines as provided by ARM 24.29.1529, reimbursement for ~~medical equipment and supplies~~ DME dispensed through a medical provider is calculated by using the RVU listed in the RBRVS times the conversion factor established in ARM 24.29.1538 in effect on the date of service. If a RVU is not listed or if the RVU is listed as null, reimbursement is limited to a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either $30.00 or 30 percent of the cost of the item. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(a) remains the same.

(3) If a provider adds value to ~~medical equipment or supplies~~ DME (such as by complex assembly, modification, or special fabrication), then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(4) remains the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the term "medical equipment and supplies" to "DME" in this rule in order to correspond with the proposed definition changes in ARM 24.29.1504. The definition is proposed to be changed from medical equipment and supplies to DME because DME is the term more commonly referred to by users of these rules. There is also reasonable necessity to clarify in the catchphrase and in the first subsection of the rule that this rule only

applies to nonfacilities. Reimbursement for DME for facilities is covered by NEW RULE I.

5. The rule proposed to be amended and transferred provides as follows, stricken material interlined, new material underlined:

24.29.1504 (24.29.1401A) DEFINITIONS As used in ~~this~~ subchapters 14 and 15, the following definitions apply:

(1) "Acute care hospital" or "hospital" means a health care facility appropriately licensed by the Department of Public Health and Human Services that provides inpatient and outpatient medical services to injured workers experiencing acute illness or trauma. Acute care hospitals are sometimes referred to as regulated hospitals.

(2) "Ambulatory Payment Classification (APC)" means the reimbursement system adopted by the department for outpatient services.

(3) "Ambulatory surgery center (ASC)" means a health care facility that operates primarily for the purpose of furnishing outpatient surgical services to patients.

(4) "Base rate" means the dollar value which is multiplied by the relative weight of the MS-DRG or APC to determine payment.

(5) "Bundling" means the practice of grouping multiple services, procedures, and supplies into one charge item instead of billing each separately.

(6) "CMS" means the Centers for Medicare and Medicaid Services.

(7) "Correct Coding Initiative (CCI)" means the code edits adopted by the department that are used to correct contradictory billing information.

~~(1)~~ (8) "Current Procedural Terminology~~" or "~~ (CPT)" codes means codes and descriptors of procedures owned, copyrighted, and ~~as~~ published by the American Medical Association.

(2) remains the same but is renumbered (9).

(10) "Durable medical equipment (DME)" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated nondurable materials and supplies required for use in conjunction with the appliance or device. The term does not include an implantable object or device.

(3) and (4) remain the same but are renumbered (11) and (12).

~~(5)~~ (13) "Healthcare Common Procedure Coding System~~" or "~~ (HCPCS)" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code. These codes also include successor codes for CPT and HCPCS established by the American Medical Association and CMS.

(14) "Implantable" means a system of objects or devices that is made either to replace and act as a missing biological structure, to repair or support a biological structure, or to manage chronic disease processes and that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to install, operate, program, and recharge the implantable.

(6) remains the same but is renumbered (15).

(16) "Inpatient services" means services rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that the patient will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use the hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.

~~(7) "Medical equipment and supplies" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated nondurable materials required for use in conjunction with the device or appliance.~~

(17) "Medicare-Severity Diagnosis Related Group (MS-DRG or DRG)" means the inpatient diagnosis classifications of circumstances where patients demonstrate similar resource consumption, length of stay patterns, and medical severity status that are adopted by the department and are used for billing purposes.

(8) and (9) remain the same but are renumbered (18) and (19).

(20) "Outpatient" means a patient who is not admitted for inpatient or residential care.

(10) through (12) remain the same but are renumbered (21) through (23).

(24) "Ratio of cost to charges (RCC)" means the computed ratio using charges and the hospital's Medicare cost report.

(13) and (14) remain the same but are renumbered (25) and (26).

(27) "Service or services" means treatment including procedures and supplies provided in a facility or nonfacility that is billable under these rules.

(28) "Status indicator (SI)" codes mean CPT codes treated in the same fashion or category, such as packaged services, and apply to outpatient services only.

(15) and (16) remain the same but are renumbered (29) and (30).

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1504 to implement changes enacted by Chapter 330. The proposed amendments add new definitions for terms used in or required by the Medicare rate schedule being proposed in NEW RULE I for services provided by a facility, as those terms are not commonly understood but are an integral part of the proposed fee schedule. The proposed amendments also transfer the rule from subchapter 15 to 14 so that all the definitions apply to both subchapters.

6. The proposed new rule provides as follows:

NEW RULE I FACILITY SERVICE RULES AND RATES FOR SERVICES PROVIDED ON OR AFTER NOVEMBER 1, 2008 (1) The department adopts the fee schedules provided by this rule to determine the reimbursement amounts for medical services provided at a facility when a person is discharged on or after

November 1, 2008. An insurer is obligated to pay the fee provided by the fee schedules for a service, even if the billed charges are less, unless the facility and insurer have a managed care organization (MCO) or preferred provider organization (PPO) arrangement that provides for a different payment amount. The fee schedules, available on-line via the internet at http://erd.dli.mt.gov/wcregs/medreg.asp, are comprised of the following elements:

(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule;

(b) The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC;

(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS;

(d) The Montana Ambulance Fee Schedule;

(e) The Montana CCI Code Edits Listing;

(f) The Montana RCC and other Montana RCC-based Calculations;

(g) The Montana Status Indicator (SI) Codes; and

(h) The base rates and conversion formulas established by the department.

(2) The application of the base rate depends on the date the medical services are provided.

(3) Critical access hospitals and medical assistance facilities are reimbursed at 100 percent of that facility's usual and customary charges.

(4) Any services provided by a type of facility not explicitly addressed by this rule must be paid at 75 percent of its usual and customary charges.

(5) Any inpatient rehabilitation services, including services provided at a long term inpatient rehabilitation facility must be paid at 75 percent of that facility's usual and customary charges. All CMS rehabilitation MS-DRGs are excluded from the Montana MS-DRG payment system and instead are paid at 75 percent of the facility's usual and customary charges regardless of the place of service.

(6) DME, prosthetics, and orthotics, excluding implantables, will be paid at 75 percent of a facility's usual and customary charges.

(7) Facility billing must be submitted on a CMS Uniform Billing (UB-04) form or CMS 1500 form, including the 837-I and 837-P form when submitting electronically.

(8) Hospitals and ASCs must, on an annual basis, submit to the department data reporting Medicare, Medicaid, commercial, unrecovered, and workers' compensation claims reimbursement in a standard form supplied by the department. The department may in its discretion conduct audits of any facility's financial records to confirm the accuracy of submitted information.

(9) Individual medical providers who furnish professional services in a hospital, ASC, or other facility setting must bill insurers separately and must be reimbursed using the nonfacility fee schedule. Those reimbursements are excluded from any calculation of outlier payments.

(10) Facility pharmacy reimbursements are made as follows:

(a) If a facility pharmacy dispenses prescription drugs to an individual during the course of treatment in the facility, reimbursement is part of the MS-DRG or APC reimbursement.

(b) If a patient's medications are not included in the MS-DRG or APC service bundle, the reimbursement will be 75 percent of the facility's usual and customary charges.

(11) The following applies to inpatient services provided at an acute care hospital:

(a) The department may establish the base rate annually.

(i) Effective November 1, 2008, the base rate is $7,735.

(b) Payments for inpatient acute care hospital services must be calculated using the base rate multiplied by the Montana MS-DRG weight. For example, if the MS-DRG weight is 0.5, the amount payable is $3,867.50, which is the base rate of $7,735 multiplied by 0.5.

(c) If a service falls outside of the scope of the MS-DRG and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) The threshold for outlier payments is three times the Montana MS-DRG payment amount. If the outlier threshold is met, the outlier payment must be the MS-DRG reimbursement amount plus an amount that is determined by multiplying the charges above the threshold by the sum of 15 percent and the individual hospital's Montana operating RCC.

(i) For example, if the hospital submits total charges of $100,000, the MS-DRG reimbursement amount is $25,000, and the RCC is 0.50, then the resultant calculation for reimbursement is as follows: The DRG reimbursement amount ($25,000) is multiplied by 3 to set the threshold trigger ($75,000). The threshold trigger ($75,000) is subtracted from the total charges ($100,000) resulting in the amount above the trigger ($25,000). The amount above the trigger ($25,000) is then multiplied by .65 (which is the RCC of .5 plus .15) to obtain the outlier payment ($16,250). The total payment to the hospital in this example would be the DRG reimbursement amount ($25,000) plus the outlier payment ($16,250) = $41,250.

(ii) The department may establish the inpatient outlier amount annually.

(e) Where an implantable exceeds $10,000 in cost, hospitals may seek additional reimbursement beyond the normal MS-DRG payment. Any implantable that costs less than $10,000 is bundled in the implantable charge included in the MS-DRG payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable.

(ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice, plus the handling and freight cost for the implantable, plus 15 percent of the actual amount paid for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(iii) When a hospital seeks additional reimbursement pursuant to this subsection, the implantable charge is excluded from any calculation for an outlier payment.

(iv) Because the decision regarding an implantable is a complex medical analysis, this rule defers to the judgment of the individual physician and facility to determine the appropriate implantable. A payer may not reduce the reimbursement when the medical decision is to use a higher cost implantable.

(f) All facility services provided during an uninterrupted patient encounter leading to an inpatient admission must be included in the inpatient stay, except air and ground ambulance services which are paid separately pursuant to the Montana Ambulance Fee schedule.

(g) The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two acute care hospitals:

(i) A hospital transferring a patient is paid as follows: The MS-DRG reimbursement amount is divided by the geometric mean number of days duration listed for the MS-DRG; the resultant per diem amount is then multiplied by two for the first day of stay at the transferring hospital; the per diem amount is multiplied by one for each subsequent geometric mean day of stay at the transferring hospital; and the amounts for each day of stay at the transferring hospital are totaled. If the result is greater than the MS-DRG reimbursement amount, the transferring hospital is paid the MS-DRG reimbursement amount. Associated outliers and add-ons are then added to the payment.

(ii) A hospital receiving a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.

(iii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

(12) The following applies to outpatient services provided at an acute care hospital or an ASC:

(a) The department may establish the base rate for outpatient service at acute care hospitals annually.

(i) Effective November 1, 2008, the base rate for hospital outpatient services is $105.

(b) The department may establish the base rate for ASCs annually.

(i) Effective November 1, 2008, the base rate for ASCs is $79, which is 75 percent of the hospital base rate.

(c) Payments for outpatient services in a hospital or an ASC are based on the Montana APC system. A single outpatient visit may result in more than one APC for that claim. The payment must be calculated by multiplying the base rate times the APC weight. If the APC weight is not listed or if the APC weight is listed as null, reimbursement for that service must be paid at 75 percent of the facility's usual and customary charges. Examples of such services include but are not limited to laboratory tests, radiology, and therapies. If a service falls outside of the scope of the APC and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) CCI code edits must be used to determine bundling and unbundling of charges. No other clinical editing is allowed to determine bundling and unbundling of charges.

(e) Outpatient medical services include observation in an outpatient status.

(f) Where an outpatient implantable exceeds $500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC payment. In such an instance, the provider may bill CPT code L 8699, and the status indicator code "N" may not be used by a payer to determine the amount of the payment. Any implantable that costs less than $500 is bundled in the APC payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable.

(ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice, plus the handling and freight cost for the implantable, plus 15 percent of the actual amount paid for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(g) The following applies to patient transfers from an ASC to an acute care hospital:

(i) An ASC transferring a patient is paid the APC reimbursement.

(ii) The acute care hospital is paid the MS-DRG or the APC reimbursement, whichever is applicable.

(iii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE I to implement changes enacted by Chapter 117 and Chapter 330 directing reimbursement for all medical services provided to a workers' compensation patient at a facility. NEW RULE I is proposed to establish payments for services provided by facilities on or after November 1, 2008, by adopting specific fee schedules designed by Medicare. However, due to the prohibition contained in 2-4-307(3), MCA, the department cannot adopt the Medicare system updates as those updates are made. Under the Montana Administrative Procedure Act, in order to adopt those updates the department is required to undertake additional formal rulemaking before those changes can be incorporated into the facility fee schedule. Accordingly, the department is proposing to adopt the Medicare schedules fixed at a certain point in time as indicated by the rule. The schedules chosen are proposed to be called the Montana fee schedules and will be posted on the department's web site. The schedules are intended to match the most recent Medicare update as closely as possible for the initial implementation of the rule.

In addition, there is reasonable necessity to adopt the provisions of NEW RULE I(8) that require providers to report certain cost information to the department. The department believes that such information is needed in order to make sure that the fee schedules do not unfairly cost-shift reimbursement rates, thus resulting in the underpayment or overpayment of costs by workers' compensation insurers. The department will coordinate with the Department of Public Health and Human Services to ensure that requests for data are not duplicated. The department notes that the reporting form for hospitals and ASCs will include information directing the provider to identify any information that the provider considers to be a "trade secret" which is protected from public disclosure under Montana law. The department intends to use the information collected to determine a reasonable method of adjusting the base rates, outliers, and implantable thresholds annually.

In setting the base rates, the department followed 39-71-704(2)(b)(i), MCA. Outliers and implantables are a part of the reimbursement reflected in the base rate level. The department will collect data and evaluate annually to determine whether an adjustment will be necessary to maintain the relative reimbursement rate proposed by this rule. The department considered developing Montana's own relative weights. Employee resource restrictions, however, do not allow developing and maintaining these data at this time. Consequently, the department upon the advice of providers and payers has adopted the Medicare weights. The department notes that although Medicare weights are used in the calculation of the reimbursement, the weights are not adjusted by Medicare's wage-index. The base rates, and the information explaining how the base rates were determined, are posted to the department's web site.

Regarding ASCs, the department believes the reimbursement level set by NEW RULE I is within a reasonable profit level for surgery centers based in part on a statement by a representative of the National Association of ASCs as a formal comment in the rulemaking process in Texas.

Finally, the department modified the definitions of the status indicator (SI) codes to reflect that these are workers' compensation codes rather than Medicare codes.

7. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to: Jeanne Johns, Workers' Compensation Regulation Section Supervisor, Workers' Compensation Regulation Bureau, Employment Relations Division, Department of Labor and Industry, P.O. Box 8011, Helena, MT 59624-8011; by facsimile to (406) 444-3465; or by e-mail to jjohns@mt.gov, and must be received no later than 5:00 p.m., September 26, 2008.

8. An electronic copy of this Notice of Public Hearing is available through the department's web site at http://dli.mt.gov/events/calendar.asp, under the Calendar of Events, Administrative Rules Hearings Section. The department strives to make the electronic copy of this Notice of Public Hearing conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that a person's difficulties in sending an e-mail do not excuse late submission of comments.

9. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request, which includes the name and e-mail or mailing address of the person to receive notices, and specifies the

particular subject matter or matters regarding which the person wishes to receive notices. Such written request may be mailed or delivered to the Department of Labor and Industry, attention: Mark Cadwallader, 1327 Lockey Avenue, P.O. Box 1728, Helena, Montana 59624-1728, faxed to the department at (406) 444-1394, e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency.

10. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled. The primary sponsor of House Bill 738 was notified on May 17, 2007, by regular mail. The primary sponsor of Senate Bill 108 was notified on May 17, 2007, by regular mail.

11. The department's Hearings Bureau has been designated to preside over and conduct this hearing.

/s/ MARK CADWALLADER	/s/ KEITH KELLY
Mark Cadwallader	Keith Kelly, Commissioner
Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 18, 2008